CLINICAL LABORATORY SERVICES PAYMENT SYSTEM

*payment***basics**

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Medicare is the largest single purchaser of clinical laboratory services. Clinical lab services are tests on specimens taken from the human body (such as blood or urine) that are used to diagnose and treat patients. Under Part B, Medicare covers medically reasonable and necessary laboratory services that are ordered by a physician or a qualified nonphysician practitioner when they are provided in a lab that is certified by the Centers for Medicare & Medicaid Services (CMS). With a few exceptions, Medicare does not cover routine screening tests unless directed to by law. Under current law, covered screening tests (with some restrictions) include cardiovascular screening tests, colorectal cancer screening tests, Pap smear tests, prostate-specific antigen tests, and diabetes screening tests.

Clinical lab services are furnished by labs located in hospitals and physician offices, as well as by independent labs. Services may also be furnished by labs located in dialysis facilities, nursing facilities, and other institutions, but frequently these tests are paid under other Medicare payment systems.

Medicare spending for lab services grew by an average of 5.5 percent per year between 2002 and 2011. This growth was primarily driven by rising volume as there were very few increases in payment rates during those years. Spending grew by 3.1 percent in 2010 but was flat in 2011 because a reduction in payment rates offset increased volume. In 2011, Medicare payments for clinical lab services totaled $8.9 billion, 1.6 percent of total Medicare spending.

To pay for lab services, Medicare uses 56 carrier-specific fee schedules established in 1985. Payment rates for each test were set separately in each carrier's geographic market, based on what local labs charged at the time; since 1985, the rates have been updated periodically for inflation. In addition, there are national payment limits that cap the fee schedule rates for each test. In practice, most lab claims are paid at the national payment limits.

Defining the product Medicare buys

Medicare sets payment rates for more than 1,100 Healthcare Common Procedure Coding System (HCPCS) codes used in billing for laboratory services. A single HCPCS code may identify more than one testing method for a given substance or more than one substance analyzed by a single method. Panel tests, which are tests commonly ordered together, have their own HCPCS codes as well.

Setting the payment rates

There is no beneficiary cost sharing for clinical lab services; therefore, the fee schedule payment rates are the total payment laboratories receive for their services. Because each carrier established its own fee schedule based upon charges from the laboratories in its region, fee schedule amounts may differ by region. CMS has transitioned from 56 carrier localities to 15 Medicare administrative contractor (MAC) jurisdictions. MACs continue to maintain the 56 different fee schedules established by carriers.

Beginning in 1986, the Congress established national limits on laboratory payment rates, called national limitation amounts (NLAs). The NLAs are set at 74 percent of the median of all carrier fee schedule amounts for each service. The payment for each service is the lesser of the providers' charge, the carrier's fee schedule amount, or the NLA (Figure 1). Because so many of the carrier payment rates are constrained by the NLAs, most lab services are paid the same national rate. Unlike most other Medicare services, payment rates for lab tests are not adjusted for geographic differences in input prices.

This document does not reflect proposed legislation or regulatory actions.

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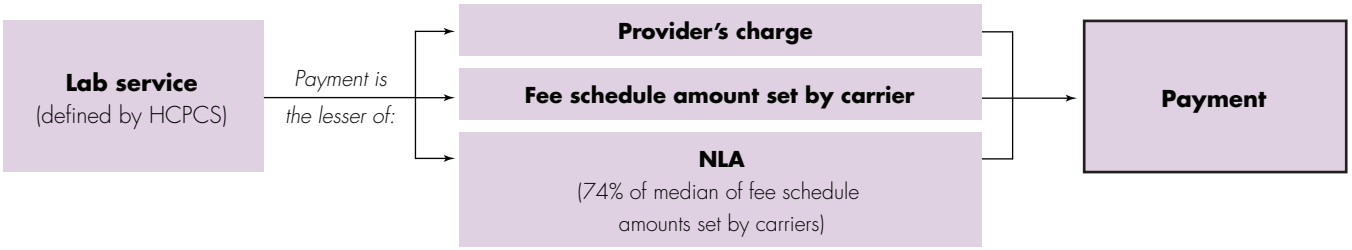
Figure 1 Clinical laboratory services payment system



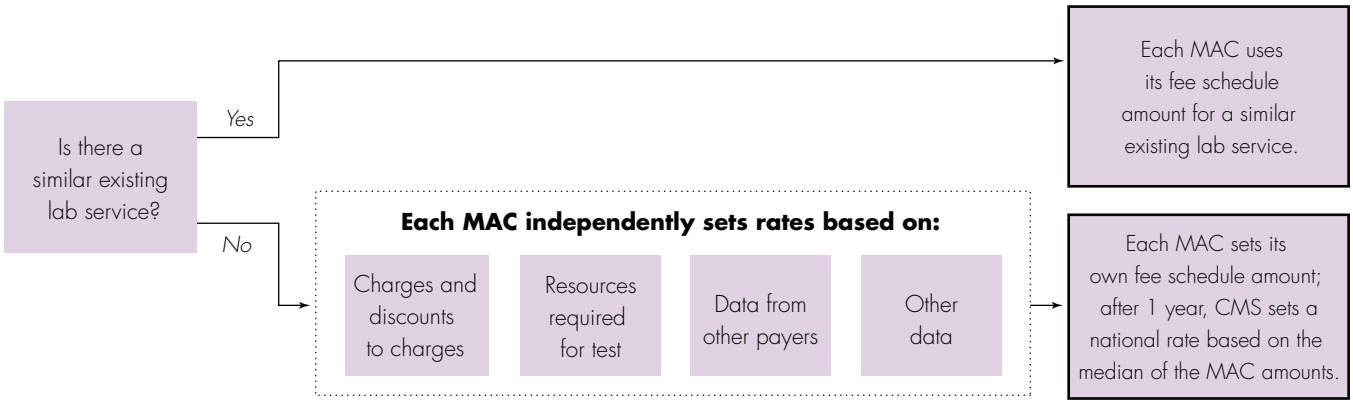
Note: HCPCS (Healthcare Common Procedure Coding System), NLA (national limitation amount). The vast majority of claims are paid at the NLA. Carriers were the CMS contractors that were responsible for reviewing and paying providers' Medicare claims. Carriers have been replaced by Medicare administrative contractors.

Initially, lab payments were adjusted for inflation annually using the consumer price index for all urban consumers (CPI–U), but since 1987 the Congress has specified lower updates. Since 1997, payments have been increased only three times, in 2003 (by 1.1 percent), 2009 (by 4.5 percent), and 2012 (by 0.65 percent)

When labs begin using newly developed tests, CMS uses a "crosswalking" method to assign payment rates based on their similarity to existing tests (Figure 2). For break-through technologies for which there are no similar existing tests, CMS relies on a "gapfilling" method in which the MACs independently set rates for the first year of use. Each MAC researches and sets its own payment amount based on charges for the test and routine discounts to charges, resources required to perform the test, data from other payers, and other information. After one year, CMS sets the national rate at the median of the MAC rates. CMS uses the crosswalking method more frequently than the gapfilling method to set rates for new lab tests. After one year, CMS may reconsider both the payment method (crosswalking or gapfilling) and payment amount for a new test. There is no mechanism for reviewing payment rates for existing tests.

Unlike other providers of outpatient clinical laboratory tests, critical access hospitals are paid for laboratory tests on a reasonable cost basis, instead of under the lab fee schedules. ■

Figure 2 Setting fee schedule amounts for a new clinical lab service



Note: MAC (Medicare administrative contractor). MACs are CMS contractors that are responsible for reviewing and paying providers' Medicare claims.